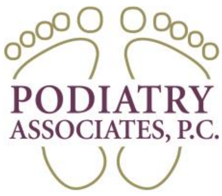


www.footdoctorscolorado.com
www.castlepinesphysicaltherapy.com
Phone: 303-805-5156
Fax: 303-805-5157

Castle Pines Foot and Ankle Clinic, PC
Castle Pines Physical Therapy and Spa, PC
7505 Village Square Drive, Suite 101
Castle Pines, CO 80108

Parker Foot and Ankle Clinic, PC
9397 Crown Crest Blvd., Alpine Bldg., Suite 311
Parker, CO 80138

Podiatry Associates at Cherry Creek, PC
Cherry Creek Physical Therapy and Spa, PC
300 South Jackson Street, Suite 310
Denver, CO 80209

Date: ____________________

PATIENT INFORMATION

Last name: __________________________________ **First name:** __________________________________ **M.I.** ______

SSN: ________________________ **Date of birth:** ___________________ **Age:** _________ **Gender:** O M O F

Ethnicity:
O Not Hispanic/Latino
O Hispanic/Latino
O Unknown

Race:
O African American
O Asian
O Caucasian
O Hispanic
O Native American
O Other

Preferred language:
O English
O Spanish
O Other: ______________

Employment:

O Disabled O Student O Full-time Employer name: ____________________________

O Retired O Unemployed O Part-time Occupation: _______________________________

O Self

Marital status: O Single O Married O Significant other O Separated O Divorced O Widowed

CONTACT INFORMATION

Street address: ____

City: ____ State: ___________________ Zip Code: __________________

Phone: Home ( ) ___________________ Cell ( ) ______________________ Business ( ) ____________________

Preferred phone number: O Home O Cell O Business May we leave a detailed message on voicemail? O Yes O No

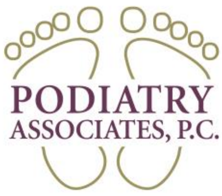
E-mail: ____

Emergency contact: ________________________ Relationship: ___________________ Phone: ( ) _________________

IMPORTANT INFORMATION

Is your visit due to a job related injury? O Yes O No Is your visit due to an automobile accident? O Yes O No

***If you answered yes to either of these questions, please notify the receptionist.**



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Name: ____ **Date:** ____________________________

In order for us to file a claim on your behalf, this section must be completed in its entirety

RESPONSIBLE PARTY FOR ACCOUNT (if different than patient)

Name: ____

Date of birth: ____________________ SSN: _____________________ Relationship to patient: ______________________

Address: ____ City: ____________________ State: _____ Zip code:_________

Phone: Home ( )___________________ Cell ( )____________________ Business ( )___________________

INSURANCE INFORMATION

Primary insurance name: ________________________________ Plan type: O HMO O PPO O Other: _______________

Policy#: ___________________________ Group#: ______________________ Effective date: _______________________

Insured name: _________________________________ Employer: ____

Date of birth: _____________________ SSN: _____________________ Relationship to patient: _____________________

SECONDARY INSURANCE

Secondary insurance name: __________________________ Plan type: O HMO O PPO O Other: ___________________

Policy#: ___________________________ Group#: ______________________ Effective date: _______________________

Insured name: _________________________________ Employer: ____

Date of birth: ____________________ SSN: _____________________ Relationship to patient: ______________________

PRIMARY CARE

Primary Care Physician: ____________________________________ Physician phone: ( )______________________

Do you want us to provide your PCP with documentation of your visits? O Yes O No

REFERRAL

How did you hear about us?

O Physician reference*:* referring Physician's name and phone number: ____

O Google O Website O Facebook O Insurance directory O Yellow pages O Twitter O Pinterest O LinkedIn

O Patient or friend's name: ___________________________ O Other (please specify): ___________________________